

# INSTRUCTIONS FOR REPORT OF EMT- PARAMEDIC CONTINUING EDUCATION

Part of State Form 18220 (R11 / 12-07)

DEPARTMENT OF HOMELAND SECURITY

- I. Certification as an emergency medical technician-paramedic will be valid for a period of two years.
- II. To renew a certification, a certified paramedic shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements below.
  - A. An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:
    1. Section IA - Forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty-eight (48) hours of supervising hospital-approved continuing education that includes the following:
      - a. Sixteen (16) hours in airway, breathing, and cardiology
      - b. Eight (8) hours in medical emergencies
      - c. Six (6) hours in trauma
      - d. Sixteen (16) hours in obstetrics and pediatrics
      - e. Two (2) hours in operations
    2. Section IB - Attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic certification expiration date.
    3. Section IC - Attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic certification expiration date.
    4. Section II - Twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section.
    5. Section III - Skill maintenance (with no specified hour requirement) - All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital, either at an in-service or in an actual clinic setting. The observed skills include, but are not limited to, the following:
      - a. Patient medical assessment and management
      - b. Trauma assessment and management
      - c. Ventilatory management
      - d. Cardiac arrest management
      - e. Bandaging and splinting
      - f. Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy
      - g. Spinal immobilization
      - h. Obstetrics and gynecological scenarios
      - i. Communication and documentation



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DEPARTMENT OF HOMELAND SECURITY

REGISTRANT INFORMATION			
Public safety identification number		Indiana certification number	Driver's license number
Printed name ( <i>last, first, middle initial</i> )		Home telephone number (      )	E-mail address
Home address ( <i>number and street, city, state, and ZIP code</i> )			
Have you been trained in NIMS / ICS? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, level of NIMS / ICS training: <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 700 <input type="checkbox"/> 800 <input type="checkbox"/> Other _____	Would you be willing to assist in a disaster? <input type="checkbox"/> Yes <input type="checkbox"/> No
VIOLATION STATEMENT			
Have you ever been charged or convicted of a crime other than minor traffic violations? <input type="checkbox"/> Yes <input type="checkbox"/> No		If you answered yes, you must attach official documentation that fully describes the offense, current status, and disposition of the case.	
SIGNATURE OF EMS MEDICAL DIRECTOR			
As the EMS Medical Director, I do hereby affix my signature attesting to the continued competence in all skills outlined in Section III of this document.			
Signature of physician		Printed name of physician	Date ( <i>month, day, year</i> )
License number	State		Telephone number (      )
Signature of physician		Printed name of physician	Date ( <i>month, day, year</i> )
License number	State		Telephone number (      )
SIGNATURE OF EMS REGISTRANT			
I, the undersigned paramedic, hereby affirm, under the penalty for perjury, that all statements on this continuing education report are true and correct, including copies of cards, certificates, and other required documents for verification. I understand that false statements or documents may be sufficient cause for revocation by the Indiana Department of Homeland Security and the Emergency Medical Services Commission. I also understand that the Indiana Department of Homeland Security and the Emergency Medical Services Commission may conduct an audit of the recertification activities listed at any time.			
Signature of paramedic			Date ( <i>month, day, year</i> )

CURRENT AFFILIATIONS - AMBULANCE PROVIDER ORGANIZATIONS		
Name of provider	Provider certification number	Telephone number (      )
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of Chief Executive Officer		Date ( <i>month, day, year</i> )
Name of provider	Provider certification number	Telephone number (      )
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of Chief Executive Officer		Date ( <i>month, day, year</i> )
CURRENT AFFILIATIONS - SUPERVISING HOSPITAL		
Name of hospital	Telephone number (      )	
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of EMS Coordinator		Date ( <i>month, day, year</i> )
Name of hospital	Telephone number (      )	
Street address ( <i>number and street, city, state, and ZIP code</i> )		
Signature of EMS Coordinator		Date ( <i>month, day, year</i> )

**SECTION IA: EMT - PARAMEDIC REFRESHER TRAINING**

1. If a formal EMT-Paramedic Refresher course was completed, please attach a copy of the certificate of completion.
2. If a formal EMT-Paramedic Refresher course was not completed, Section I must be completed in its entirety. All signatures must be original.
3. All in-services and refresher courses must be done at or approved by your Supervising Hospital.
4. Lecture hours can only be assigned to one category of in-service credit in Section I.

DATE (month, day, year)	NUMBER OF HOURS	TOPIC	INSTRUCTOR'S SIGNATURE
Division I - Airway, Breathing, and Cardiology			Required: 16 hours
Division II - Medical Emergencies			Required: 8 hours
Division III - Trauma			Required: 6 hours
Division IV - Obstetrics & Pediatrics			Required: 16 hours
Division V - Operational Tasks			Required: 2 hours

**SECTION IB: CPR CERTIFICATION**

Attach a copy of the front of your  
current provider card or certification.

**SECTION IC: ACLS CERTIFICATION**

Attach a copy of the front of your  
current provider card or certification.

**CPR and ACLS certification hours may be added to the appropriate divisions in Sections I and II.**

## SECTION II: 24 ADDITIONAL HOURS OF CONTINUING EDUCATION

12 hours must be obtained as AUDIT & REVIEW
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[illegible]

### SECTION III: VERIFICATION OF SKILL COMPETENCE

1. No specific amount of time must be spent on each skill or combination thereof.
2. All skills must be directly observed by the EMS Medical Director or EMS educational staff of the Supervising Hospital, either at an in-service or in an actual clinical setting. All signatures must be original.

SKILL	DATE ( <i>month, day, year</i> )	INSTRUCTOR'S SIGNATURE
A. Medical Assessment / Management		
B. Trauma Assessment / Management		
C. Ventilatory Management		
D. Cardiac Arrest Management		
E. Bandaging and Splinting		
F. Medication Administration, IV Therapy, IV Bolus, and IO Therapy		
G. Spinal Immobilization		
H. Obstetrics and Gynecological		
I. Communication and Documentation		